There is a need for a prospective, multicenter study to document the most effective diagnostic and treatment regimens for this disorder. Early results indicate, however, that patients can achieve substantial hearing improvement or stabilization with immunosuppressive therapy.

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REFERENCES

Arnold W, Pfaltz CR: Critical evaluation of the immunofluorescence microscopic test for identification of serum antibodies against human inner ear tissue. Acta Otolaryngol 1987; 103:373

Harris JP, Sharp PA: Inner ear autoantibodies in patients with rapidly progressive sensorineural hearing loss. Laryngoscope 1990; 100:5

Hughes GB, Barna BP, Kinney SE, Calabrese LH, Nalepa NL: Predictive value of laboratory tests in 'autoimmune' inner ear disease: Preliminary report. Laryngoscope 1986; 96:502-505

Hughes GB, Kinney SE, Barna BP, Calabrese LH: Autoimmune inner ear disease—Laboratory tests and audiovestibular treatment responses, *In* Veldman JE, McCabe BF (Eds): Otoimmunology. Amsterdam, The Netherlands, Kugler, 1987, pp 149-155

Transoral Approach to Mandibular Angle Fractures

FRACTURES OF THE ANGLE are among the most common seen in mandibular fractures. Intermaxillary fixation with or without interosseous wires has been a major component of the treatment of angle fractures, but the fixation wires must stay in place for six weeks.

Mandibular plating has recently gained in popularity, as the fixation wires can be removed immediately. This technique works well on the body of the mandible, but angle fractures can be troublesome. The disadvantages of using plates at the angle include the need for a large skin incision and the possibility of damage to the facial nerve. An alternative is to plate the mandible through an intraoral incision just behind the third molar. Strict attention must be paid to the effect of the forces that the muscles of mastication apply to the ends of a fracture. A mandibular miniplate is used to direct the forces of mastication to compress the fractured ends together. This does not provide completely rigid internal fixation allowing the immediate removal of the intermaxillary fixation, as placement of a larger plate would, but it does avoid a large external incision.

The recommended period of intermaxillary fixation is two weeks, as opposed to six for other techniques. At that point, the patient is reevaluated and may be placed in elastic band fixation for one more week, or the fixation may be removed if the fracture is stable and the reduction is good.

The advantages of this technique are that there is no external incision, these smaller mandibular miniplates are easier to contour properly and should not be visible through the skin, the fixation requires a shorter time, and the ease of surgical approach and placement leads to a shorter operative time.

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REFERENCES

Ikemura K, Hidaka H, Etoh T, Kabata K: Osteosynthesis in facial bone fractures using miniplates. J Oral Maxillofac Surg 1988; 46:10-14

Nishioka GJ, Van Sickels JE: Transoral plating of mandibular angle fractures: A technique. Oral Surgery 1988; 66:531-535

Spiessl B: Internal Fixation of the Mandible: A Manual of AO/ASIF Principles. Berlin-New York, Springer-Verlag, 1989, pp 51-59